



Phone: 314.434.5858 Fax: 314.434.6541  
 www.havenhousetl.org

## HOSPITAL REFERRAL

Please fax this completed form to HavenHouse St. Louis

Hospital:
Doctor:
Patient Department:
Person Referring:
Phone Number:

PAYMENT INFORMATION	
Who is responsible for daily fee? Check one and fill out.	
<input type="checkbox"/>	Family (Self-pay)
<input type="checkbox"/>	Hospital: _____
<input type="checkbox"/>	Other: _____
Additional Information:	

Check-in Date:	
Check-out Date:	
PATIENT INFORMATION	
Patient Name:	
Patient D.O.B.:	
Guardian Name (N/A, if self):	
Address:	
City:	
State:	Zip:
Phone Number:	
Alt. Phone Number:	
Additional Patient Information:	

LIST ALL INDIVIDUALS STAYING IN THE ROOM		
***One must be <u>21</u> years or older***		
Name	Relationship to Patient	Age
Other Guest Needs:		

OFFICE USE ONLY
-----------------